E S T A B L I S H I N G

D I L A A S A

Documenting the challenges

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C O N T E N T

I. INTRODUCTION

About *Dilaasa*

Dilaasa, Crisis Centre for Women is the first hospital-based crisis centre in India designed to respond to the needs of women facing violence within their homes and families. The Centre is a joint initiative of the Public Health Department of the Brihanmumbai Municipal Corporation (BMC) and the Centre for Enquiry into Health and Allied Themes (CEHAT), a Mumbai-based multi-disciplinary non-governmental institution promoting and supporting socially-relevant health and related research, action, services, and advocacy.[1]

Dilaasa represents the first attempt in India to sensitise the public health system to domestic violence through the establishment of a public hospital based crisis centre. The goals of this partnership between the non governmental organisation (NGO) and a Government organisation were to (1) institutionalise domestic violence—and more broadly, violence against women—as a legitimate and critical public health concern within the government hospital system, and (2) build the capacity of hospital staff and systems to adequately, sensitively and appropriately respond to the health needs of the victims and survivors of domestic violence. *Dilaasa* is located in K B Bhabha Hospital, which is one of the 16 peripheral general hospitals of the BMC[2].

(i) Domestic Violence A Health Issue

Domestic violence is a common form of violence against women. Domestic violence—also called 'intimate partner abuse', 'battering', or 'wife-beating'—is defined as an ongoing experience of physical, emotional, financial, and/or sexual abuse faced by women within the household. It is characterized by long-term patterns of abusive behaviour and control [Human Rights Watch, 2003]. The abuser/s could be a woman's husband and/or other members from the natal or marital families. Domestic violence is not specific to any culture or community; it cuts across the boundaries of class, caste, religion, race and nation. It is rooted in the social, economic, political and cultural structures, that place women in unequal and vulnerable positions. As this violence takes place within the 'home' it is considered a personal and private matter, not a serious public health issue.

Prevalence

While uniform national prevalence rates of domestic violence do not exist—due to differences in the definition of violence, research methodologies, and region—research studies conducted within India indicate that the abuse is widespread and grossly underreported [Jesani 2002]. A study conducted in rural villages of Karnataka [Rao 1997] indicate that 22 per cent of women had been assaulted by their husbands. Research conducted among lower-caste communities in Chandigarh, Punjab indicates a lifetime physical violence prevalence rate of 75 per cent, while two-thirds of these women reported regular physical beatings [Mahajan 1990].

[1] CEHAT is a research centre of the Anusandhan Trust.

[2] The BMC provides health care services in the city of Mumbai, which has a population of 119 lakhs. The Public Health Department of the BMC is structured as a three-tier system—the tertiary level consists of three major hospitals and one dental hospital; the secondary level consists of 16 peripheral general hospitals and 5 specialty hospitals; and the primary level encompasses 23 maternity homes, more than 2000 dispensaries, and 212 health posts.

Other community-based studies indicate a prevalence rate of 66 per cent (rural Gujarat), 36—38 per cent (Tamil Nadu), and 42—48 per cent (Uttar Pradesh) [Visaria 1999; Jeejebhoy 1998]. A multi-site national study conducted by the International Centre for Research on Women (2000) found that 40 per cent of women had experienced physical marital violence at least once in their lives, 44 per cent of women had faced psychological abuse, and 26 per cent of women had faced physical violence or forced sex in the previous 12 months. A 2002 study by the National Family Health Survey indicates that 21 per cent of women in India had experienced one or more episodes of violence since the age of 15 years and 19 per cent had faced physical abuse perpetrated by their in-laws.

Studies conducted in health care settings indicate that women approach public hospitals for treatment of health complaints and injuries caused by domestic violence. A 1996 Mumbai-based study examined cases of women (above 15 years of age) recorded in the Emergency Police Register of the Casualty Department in a public hospital located in Mumbai. It found that 22.4 percent of cases were definitely due to domestic violence (the survivors themselves reported violence carried out by family members) and another 44.3 percent were possible cases of domestic violence (it was suspected that women suffered from domestic violence, but were unable to report the incident/s).Two-thirds of the women above 15 years (66.7 percent or 497/745) were definitely or possibly,
victims of domestic violence. [Daga 1998].

Health Consequences of Domestic Violence

Gender-based violence manifests in many forms: sex-selective abortion, incest, trafficking, marital rape and other forms of sexual assault, sexual harassment in the workplace, forced suicide, honour killings, dowry-related homicide, and various forms of physical and emotional abuse perpetrated by intimate partners. Gender-based violence has severe consequences for the physical, emotional, and social well-being of women victims and survivors. Violence impacts women's health in myriad ways—both directly and indirectly—and can lead to chronic debilitating conditions and even death.

The severest health consequence of domestic violence perpetrated by intimate partners and family members is homicide [Campbell and Lewandowski, 1997]. In the US, domestic violence accounts for more than one-half of the homicides of women each year [Fagan and Browne, 1994; Campbell and Lewandowski, 1997]. This body of research also indicates that the majority of murdered adult women are killed by their husband, partner, ex-husband, or ex-partner and in the majority of murder cases, the woman was battered when she was alive [Campbell and Lewandowski, 1997]. In India, the Maharashtra Vital Statistics Hand Book (1996) records that the single largest cause of death among women in the state is burns, drowning and/or suicide (26.3 percent), many of which are believed to be directly related to domestic violence [Tathapi 2001].

Physical health consequences directly linked to intimate partner violence include broken bones, facial trauma (such as fractured mandibles), tendon or ligament injuries, chronic headaches (a likely result of neurological damage from the untreated loss of consciousness often reported by battered women), undiagnosed hearing, vision and concentration problems (also possible due to neurological damage from injuries sustained), chronic irritable bowel syndrome, and other stress-related problems [Campbell and Lewandowski, 1997]. Abuse during pregnancy can lead to low birth weight outcomes, infection (particularly related to forced sex during pregnancy),

worsening of chronic problems already demonstrated by the pregnant woman (such as hypertension and diabetes), as well as miscarriage.

The primary mental health consequence of battering within an ongoing intimate relationship is depression and the strongest risk factor for identifying women facing violence in one study based in a primary health care setting was found to be depressive symptomology [Hamberger et al1993; Campbell & Lewandowski, 1997]. Research on the association between depression and domestic violence consistently demonstrates greater depressive symptomology among battered women as compared to other women [Gleason 1993; McCauley et al 1996; Ratner, 1993]. In fact, the frequency and severity of current physical violence and stress are greater predictors of depression among battered women, than are prior histories of mental illness or demographic, cultural, and childhood factors [Campbell and Lewandowski 1997]. High rates of post-traumatic stress disorder (PTSD) are also well documented in battered women and the strongest indicator of PTSD illustrated by research to date is the severity of current violence [Campbell and Lewandowski, 1997]

Other mental health consequences of violence include: feelings of anger and helplessness, self-blame, anxiety, phobias, panic disorders, eating disorders, low self-esteem, nightmares, hyper vigilance, heightened startle response, memory loss, and nervous breakdowns. Violence can also give rise to unhealthy behaviour such as smoking, alcohol and drug abuse, sexual risk-taking, and physical inactivity. Self-harming behaviour is also a serious consequence of victimisation and includes refusal of food and drinking, suicide ideation and attempts, and generally neglecting oneself and one's health.

(ii) Placing *Dilaasa* within the women's movement struggle

The women's movement in India brought violence against women as an issue into the public domain in the 1970s. The rape of Mathura, a tribal girl by two policemen became the starting point of the anti-rape struggle that began in Mumbai and then expanded to other cities in India. The Forum against rape was established at the beginning of 1980 and it brought into the public domain the question of male violence for the first time in India in addition to the class and caste violence that had been long highlighted. The years after that witnessed agitation, mass campaigns, public education, legal reform and advocacy to raise awareness about these forms of violence and eliminate them. Legal strategies too were evolved and the outcome of this work includes the repeal of rape laws, the introduction of 498A in 1983, the repeal of laws pertaining to dowry deaths and sati, the Supreme Court guidelines for sexual harassment at the workplace, and the introduction of the law criminalizing sex-determination tests.

Later violence within the family drew serious attention through dowry deaths or bride burning and then, the issue of battering. Silence and social stigma over the issue of domestic violence was also being broken at around the same period. Work against domestic violence took roots when women in the movement publicly fought the abuse they had faced in their homes. They used the slogan 'the personal is political' to successfully demystify the 'private' space that is the home. This made it possible for individual women to come forward and share their agony and pain. The issue of domestic violence was highlighted as a gross violation of the rights of women citizens. This movement asserted that all women have the right to violence-free lives and that domestic violence inhibits women from realising their rights and full potential in all other aspects of their lives – in their social, economic and political spheres.

In addition to raising awareness about violence against women, autonomous women's groups as well as NGOs established some infrastructure and services to care for and provide support to women victims of violence. The state has had to respond to the growing pressure created by the sustained campaigns taken up by these groups on the issue of violence. The last two decades, have seen the establishment of free legal cells and Special Cells at police stations in the city of Mumbai. These have helped individual women and, to a certain extent, sensitised the public systems to respond to the issue of domestic violence.

While the serious health consequences of domestic violence for women are well-researched and established, the role of the public health system in responding to the issue has not received adequate attention. The women's movement has confronted the health system for its coercive population policies and highlighted the lack of sensitivity while dealing with reproductive and sexual health needs of women and the complete lack of gender sensitivity within the system. The women's movement and the health movement have highlighted several lacunae in the existing health system, for example, the failure to document important forensic evidence in the event of rape and sexual assaults that severely limits survivors' ability to attain justice. Similarly, in cases of domestic violence, it is imperative to document both the recent episodes of violence as well as the woman's history of victimization. Such documentation is critical in divorce and criminal cases to seek compensation. Most often women decide to seek legal action only after the violence has escalated but they have no documentary evidence to prove it. So, although violence by the health system was a serious issue within the women's movement, this effort to work closely with the system was not seen favourably.

(iii) Public Health System: Critical site for intervention

The public health system is an important site for the implementation of anti-domestic violence intervention programmes for a number of reasons. First, the health care system is often the first contact for victims and survivors, who approach health care providers for treatment of the resulting physical and psychological post-violence trauma. Second, the public health system occupies an important role in the struggles of victims and survivors to achieve justice. It is the only institution that can produce medical and forensic evidence formally recognised by the criminal justice system. For example, only a public hospital has the authority to register medico legal cases (MLCs). For victims and survivors of domestic violence, the public hospital is also the only place where treatment can be obtained because private practitioners often turn away cases of suspected violence, such as rape or assault. Thirdly, given the unique position of health professionals, women are more likely to share the actual cause of injury with a doctor than anybody else. A woman may not go to the police station or counselling centre but would share the experience of abuse with a doctor. In addition to providing an opportunity for intervention with victims and survivors of violence, the system provides a place where gender and violence sensitisation programmes targeting the general public, health care providers, administrators, policy makers, and project developers can be carried out.

However, medical professionals are not adequately equipped to sensitively respond to the issue of violence against women. Lack of training and education on this issue, general indifference to dominant societal norms that legitimise violence against women are only some of the reasons for the inability of the professional to respond effectively to the needs of victims of violence. There is evidence that, even when women facing violence are identified within the health care system, providers have a tendency to focus on the physical consequences of abuse, to be condescending and distant, and to blame

women for the violence they face. [Campbell and Lewandowski 1997; Kurz and Stark 1988; Layzer et al 1986; Vavarro et al 1993; Warshaw 1989, Daga 1998]. Within the medical context, violence is understood as a social problem and/or private family matter, as it does not fit into the traditional illness model. As noted elsewhere, "The concern for violence is conspicuous by its virtual absence in medical discourses. The special medical needs and rehabilitation of victims and survivors of violence are hardly ever discussed by doctors" (Jesani 1995). As a consequence, in India, the medical education system does not address violence as a health problem, nor does it include training or even information on responding to victims and survivors. This lack of training is among the most challenging barriers to sensitising the public health system to the needs of women survivors of violence.

Formative research by the *Dilaasa* project team illuminated a number of behavioural patterns, perceptions, and beliefs held by medical professionals with regard to their roles in responding to the needs of victims of violence. Significantly health care providers did not see domestic violence as a health issue; rather, they perceived it to be a personal and family matter, in which they should not interfere. (*See pg. 16 of Formative Period)* They show considerable resistance to documenting current episodes and the history of violence, and providing necessary referrals to other services.

When a woman who has suffered domestic violence approaches the health care system, her physical injuries are treated by health professionals but she is not provided with any emotional support. Furthermore, earlier episodes of violence and the resulting injuries are often not recorded. If, in her first contact with the health system, she is provided with emotional support, treated sensitively and referred to counselling and social support services, she would be in a better position to resist, reduce and stop the violence in her life. While there are many women's organizations providing counselling services for women facing domestic violence, there have been no systematic or formal efforts to sensitise health care professionals to this issue and the critical role they can play in screening, documentation, treatment and referral.

(iv) CEHAT's work

CEHAT, research centre of Anusandhan Trust, through its Research, Action, Service provision and Advocacy (RASA) has been addressing issues of right to health care to all as well as preventing violence and caring for survivors. CEHAT was established to conduct academically rigorous and socially relevant health research and undertake health action for the well being of the disadvantaged masses, for strengthening people's health movements and for realising the right to health and health care. Work at CEHAT has developed along four inter-related themes: (i) Health services and financing; (ii) health legislation, ethics and patients' rights; (iii) women and health, and (iv) investigation and treatment of psychosocial trauma. CEHAT's work is directed at demanding access to health and health care as a right, and investigating and combating violence. Anusandhan Trust and CEHAT have pioneered work on violence as a health issue since 1991. They have participated in the investigation of violence and assisted human rights lawyers in getting justice for the survivors. They have also conducted studies, written extensively on the subject, conducted education and training for university students, doctors, teaching faculties, NGO staff and government officials.

CEHAT's work on violence has addressed issues of violence against women (domestic violence, sex determination and sex selection and sexual assault); violence against children (investigation into conditions of juvenile homes), violence by state agencies (investigation of torture, police custody deaths and atrocities by police) and caste and communal violence. The issue of domestic violence was taken up as the starting point

of the organization's work to legitimise human rights issues within the public health system through conducting research and service provision for victims of violence. It was thought that once the public health system became sensitive to this issue, the adoption and incorporation of other human rights issues into the system would be relatively easy.

At the time *Dilaasa* was being conceptualised, CEHAT had prepared a systematic review of various studies on violence against women in India and had begun the process of establishing a women-centred and community-based action and research project in a slum in Mumbai through *Arogyachya Margavar* (1998—2003). Here (1) community women were trained to respond to primary and reproductive health care needs and domestic violence, and (2) research was undertaken on the nature and magnitude of domestic violence in the community. The goals of the research study were: to study the levels and determinants of domestic violence, to identify the perpetrators and precipitating factors of incidents of domestic violence, to examine help-seeking behaviour and coping mechanisms utilized by victims, and to understand the social and economic roots of violence against women.[3] Around this time CEHAT had begun to focus on concerns around violence against women by linking up with the public health services provided by the Brihanmumbai Municipal Corporation and discussions had been initiated with high-ranking officials of the BMC and a hospital to establish a crisis centre.

CEHAT's engagement with this community-based domestic violence project strengthened its ability to convince the officials of the BMC to start a hospital based crisis centre. The implementation of *Dilaasa* is not only an addition to CEHAT's prior work on domestic violence, but represents the mainstreaming of this issue into a larger public structure.

[3] Through surveys and informal group discussions with married women in the community, the study found that: 64 per cent of women reported violence at some point in their marital lives; 17 per cent reported violence during the 12 months prior to the study; psycho-social violence was most prevalent, followed by physical and economic violence; if it does occur, violence is most likely to occur in the first year of marriage; women facing violence experience serious health problems, 5 per cent of the women facing violence reported that they had attempted suicide; prevalence was greater among younger women; lower prevalence rates were associated with minimal age differences between spouses and lower age of women at marriage, and most women seeking help utilised informal support systems in response to the violence they were facing. In the process, CEHAT helped to facilitate the emergence and registration of Astitva Mahila Mandal, a self help group.

II. DILAASA'S MODEL OF COLLABORATION

The concept of a one stop crisis centre developed during a workshop on reproductive health and rights organized by the Ford Foundation in 1998 in Jodhpur, Rajasthan, Dr Amar Jesani (then Coordinator of CEHAT) learned from a participant from Malaysia about their efforts to set up a One Stop Crisis Centre (OSCC) in public hospitals for victims of domestic violence. These crisis centres were based in public hospitals, were jointly staffed by both NGO and hospital representatives, and provided a range of services—psychological, medical, legal, and social—necessary for the care of victims of domestic violence. The experience of these centres underscored the potential for similar successful partnerships between the public sector and NGOs or grassroots political / people's organizations in India. During this meeting, a discussion ensued about the possibility of setting up similar centres in India. The Programme Officer at Ford Foundation at the time, Geetanjali Misra, was enthusiastic and open to exploring this possibility with CEHAT.

Partnership with BMC

The CEHAT coordinator continued to explore various aspects of NGO-governmental collaboration on domestic violence. CEHAT was affiliated with the Women-Centred Health Project (WCHP), a joint initiative of BMC and SAHAJ, an NGO, to sensitise the health system to women's health issues and improve the quality of reproductive health care services delivered at the primary level. CEHAT provided support and technical assistance for this project. Because of this prior involvement with the BMC in a collaborative project on women's health, the potential for a domestic violence project seemed promising. Amar organized a meeting with the then Executive Health Officer of the Public Health Department of the BMC, Dr Alka Karande, during which he talked about the Malaysian experience of setting up an OSCC. He also described CEHAT's perspective on violence as a public health issue and the work already being done by local women's groups and NGOs to provide counselling and support services to victims and survivors of domestic violence. Dr Karande was very responsive to Amar's query about the possibility of setting up similar centres in municipal hospitals in Mumbai. Dr Usha Ubale, another health officer involved in the BMC's Women-Centered Health Project too was enthusiastic about the idea.

Following this positive response, a tour of Malaysia and the Philippines was organized to visit and study the various crisis centres set up in public hospitals in collaboration with NGOs to meet the needs of women facing domestic violence. The purpose of this study tour was to learn specific strategies for setting up such a centre and how they could be structured in the Indian context. The Ford Foundation supported CEHAT's efforts to initiate the project and establish a partnership with the BMC, including the study tour to Southeast Asia.

Dr Amar Jesani, Geetanjali Misra, three officers of the Public Health Department of the BMC (including Dr Usha Ubale and Dr Alka Karande) and Dr Seema Malik. Dr Malik was chosen to participate in this study tour because by then it was clear that Bhabha Hospital would most likely be the site for the centre.[4]

[4] Initially, the V.N. Desai hospital had been considered as a prime site for the Centre because the WCHP was already conducting training sessions here for the staff of the dispensaries, maternity homes and health posts attached to the hospital. This, it was felt would facilitate the development of a strong referral system for domestic violence victims/survivors. The Medical Superintendent of V N Desai hospital at that time was responsive to the idea of setting up such a Centre. However, she was on the verge of retirement. Efforts were then made to find another hospital and a responsive Medical Superintendent.

In addition to Dr Malik's enthusiasm and background in women's health (obstetrics/gynaecology), there were a number of factors which led to Bhabha Hospital being selected: It was a medium sized hospital with all the essential departments; there was space available for the project, and it was centrally located serving a large population. The hospital was also well-connected with medical schools and students completed their residencies here. Additionally, the Medical Superintendent had greater autonomy over the functioning of the hospital than would have been the case in a teaching hospital. Dr Malik's commitment to the project was reinforced after seeing such crisis centres elsewhere. The study tour allowed her to see the actual running of the crisis centre model and see how it could actually be set up and implemented in collaboration with an NGO. It enabled her to give whole hearted support to the setting up of a centre to deal with the problem of domestic violence.

Insights from the study tour

The study tour provided a number of key inputs to the shaping and structuring of *Dilaasa*. These were:

- A hospital provides an excellent opportunity for intervention and support work for women facing domestic violence as all severe episodes of violence are reported at the casualty department of public hospitals. By starting work at the hospital level we could respond to women facing severe violence. These would be women who are at high risk.
- A proper room and space must be created within the hospital for the Centre.
- The Centre should be near and on the same floor as the Casualty Department so that women do not get lost or have to spend time in finding their way to the Centre. The pathway from the Casualty Department to the Centre should not be intimidating or frightening in any way, particularly as they are likely to be in a traumatized state at the time they come to the hospital.
- The Centre should not be close enough to the Casualty Department to be disturbed by the hustle and bustle there; there should be some distance between the two.
- There should be a good referral system in the hospital. The staff must be sensitised to the issue of domestic violence as well as their respective roles in addressing it.
- The method of feminist counselling—to which participants were exposed during their visit to a crisis centre in the Philippines—can be beneficial for women victims and survivors.

DILAASA'S MODEL OF COLLABORATION

The collaboration between CEHAT and the BMC is significant for many reasons. CEHAT had demonstrated commitment and expertise on women and health issues and also on human rights and a public hospital has the facilities and the capacity to respond to victims and survivors because of its accessibility. No NGO despite its best efforts can possibly reach out to as many women as could a public hospital. NGOs can at best set up excellent models with limited reach. If however efforts were to be made to create a space in the public hospital, it would be safe and accessible to women. This would encourage the state to respond to domestic violence. CEHAT therefore chose to work closely with the system and dialogue and invest in the system to transform it. This, we thought was the best way to realise the rights of victims and survivors of violence. Such public hospital-based crisis centres would help us to project domestic violence as a public health issue and a violation of women's human rights. The partnership and joint ownership between an NGO and a government agency would ensure the full involvement of the hospital staff so that the centre would not remain an NGO-run initiative.

We were convinced that through such a collaboration we would be able to transform the culture of the health system to incorporate the perspective of domestic violence as a health issue.

Project structure

The project is unique in that it has been conceptualised and implemented as a joint project—in terms of human resources, leadership and management. This is also its strength. The project structure evolved keeping in mind the needs of the women, the constraints of a hospital system and how best our objective would be served. The *Dilaasa* project team comprises professionals from both CEHAT and the public hospital system. The project's lead position project director is occupied by the Medical Superintendent of the Hospital. The project coordinator is from CEHAT and is responsible for coordination and implementation of all the activities of the project.

All decisions regarding the project, such as policy, programme activities and future direction, are taken jointly by representatives of both CEHAT and Bhabha Hospital. With the aim of making this process democratic and participatory, it was decided to form a coordination committee chaired by the Medical Superintendent of Bhabha Hospital. The committee would meet at least once a month. The members of the Coordination Committee were the project director, the project coordinator, a counsellor from CEHAT and the social worker from the hospital. This committee was to take all decisions related to the project. However, this committee remained functional only for a short period because of several reasons. There were time constraints and difficulties in adopting a participatory and democratic mode of functioning in a set-up that was as hierarchical as the hospital system. In practice, while the team led by the Project Coordinator functions in a participatory way, the final decisions are taken in meetings held between the project director and project coordinator.

The jointly developed project proposal had decided that an advisory committee be set up to provide direction and extend support to the project. The members of the advisory committee were : the Executive Health Officer (Chairperson), Dr Kathuria; the Medical Superintendent of Bhabha Hospital (Secretary), Dr Seema Malik; the Coordinator of CEHAT, Ravi Duggal; a representative from the State Government, Nirmal Samant Prabhawalkar, Chairperson State Women's Commission; a representative of women's groups - Aruna Burte; Laxmi Lingam, Director Unit for Health Studies, Tata Institute of Social Sciences, Indira Jaising, feminist lawyer, Sheela Tewari and Sabala (2003).

The committee drew members from state agencies as well as those regarded as experts from the field in the hope that the project would gain recognition and their presence would help in advocacy for such work. The committee met three times during the project period.

Consultants

We also felt the need to seek regular support from experts in the area of intervention in domestic violence. For, while we had imbibed lessons from experiments in other countries, we had no idea how such an initiative would be accepted by all concerned. We felt that all activities and strategies should be reviewed for their effectiveness and improved upon as and when required.

Both partners, CEHAT and BMC together prepared a mutually agreed upon list of consultants for the project. They were: Dr Amar Jesani, Aruna Burte, Manisha Gupte, Radhika Chandiramani and Renu Khanna. Their rich experience of working on health and domestic violence has been useful to the project in all its stages. Over the project

period, the team has consulted them on various aspects of all its activities- research, training and service provision.

The objectives of the collaborative project were:

1. To assist the Public Health Department of the BMC in setting up and running a crisis centre for women survivors of domestic violence at the K. B. Bhabha Municipal General Hospital, Bandra West, in Mumbai.
2. To assist the public health department of the BMC in creating a conducive environment and conditions for inter-departmental collaboration, and for collaboration with the NGOs and other concerned groups for running the crisis centre for women in the hospital. Such collaboration would be based on mutual respect, and on the principle, that care of the survivors would be the dominant concern.
3. In the last year of implementation, to help the BMC in making the programme a part of its services, to link it up with its peripheral institutions and to replicate it in other hospitals in Mumbai as well as outside.

The specific roles and responsibilities of both of the partner organizations were clearly delineated in the Memorandum of Understanding (MOU) between CEHAT and the BMC. According to this document, the BMC was to provide the following substantial contribution to the project:

Space

Three large rooms close to the Casualty were provided free of charge for use for counselling, legal aid, documentation and training. Two rooms for the crisis centre work were on the ground floor of the hospital opposite the casualty department and one was on the third floor for training and documentation. The conference hall was made available for conducting training.

24-hour shelter

Provision of 24-hour temporary shelter for women survivors in one of the wards of the hospital by allotting five to 10 beds for the crisis centre. Due to several problems related to administration, this could not be realised in the manner that it was envisaged. Several problems needed to be resolved first: Who would take responsibility of such a shelter? The BMC rules do not permit children with adults into the hospital, so where would the children go? If a woman leaves or commits suicide, who would be responsible? The issues remained unresolved and despite our best efforts we have been unable to get the authorities to provide this much-needed service. But temporary shelter in the form of admission to one of the wards has been made possible, but only for women who had medical problems.

Staff

The BMC was to depute a nurse, a social worker, and a part time doctor. Of these a full time social worker, a part time doctor as well as a clinical psychologist has been deputed part time on the project. A core team comprising 12 staff from the hospital as trainers has also been constituted. While only one person was deputed full time on the Centre, staff for conducting training was made available. The deputation of only one staff member for running of the centre is a handicap at the end of the project as one person cannot manage the case load. We tried our best but were unable to get an additional staff deputed for centre work.

Medical and referral support

The departments and staff of Bhabha and other municipal/government hospitals would provide referral and medical support to the survivors of violence free of cost, including investigations and their medical and surgical treatment. This was provided under the hospital rules with regard to exemptions of charges by the social worker of the hospital.

The role of CEHAT was to:

1. *Provide trained staff for the project*: CEHAT recruited staff that worked full time on the project. The staff had adequate skills to implement the various activities of the project. Consultant and resource persons too were requested to give inputs. There was an ongoing process of training of the recruited staff so as to ensure quality.
2. *Technical assistance in setting up crisis centre:* We assisted the hospital in all possible ways to set up the centre. From renovating the rooms in such a way that confidentiality could be ensured for women seeking counselling, to developing procedures and protocols at the Centre to define the centre's policy, goals, objectives and limitations. This process was done in a dynamic way by involving the BMC staff and outside resource persons. There was dialogue, heated debates and arguments too! Linkages with other organisations too were established.
3. *Sensitisation and training of BMC staff:* The staff was not just sensitised but was trained as trainers too. We ensured that they develop the capacity to train other health personnel. Although this was a slow and gradual process, the team decided to do it so as to build capacity and sustainability beyond the project period.
4. *Secure funds for the project:* CEHAT obtained funds from the Ford Foundation for this endeavour.

As the ultimate goal of this pilot project is to fully integrate and institutionalise the Crisis Centre with the Hospital, CEHAT will ultimately withdraw from managing the project to allow complete ownership of *Dilaasa* by the BMC. Currently, CEHAT continues to be involved in the day-to-day planning, management, and implementation of services. In the next three years, the NGO will work towards further integrating and expanding the activities of *Dilaasa* within the health services system, including the replication of the *Dilaasa* model in other peripheral hospitals in Mumbai.

Strategies used at implementation level to integrate project/issue into the system

- *Dilaasa* has been established as a department of the hospital. This was done to ensure that it is able to create its own relational and functional space and establishes links with other departments and staff. This also means that this department is on par with other departments of the hospitals.
- Conscious effort was taken to ensure that all correspondence and liaison was done in the name of *Dilaasa*. This was followed both within the hospital as well as with outside organisations/agencies. This helped greatly as the *Dilaasa* team developed an identity of its own. Although the members of the team were from CEHAT and the BMC, all the policies and rules for the centre were developed together.
- *Dilaasa* was run in the name of the BMC so the staff of the hospital have identified with it as their department. All public relations activities are handled by the BMC personnel. Apart from the promised deputed staff, the medical superintendent also allowed and supported the formation and sustenance of a core group of key trainers. While it is to its credit that it took up the responsibility of training over and above all the other work of the individuals involved, this was made possible because of the leadership of the hospital. The *Dilaasa* team too responded and engaged in intense dialogue with this group. CEHAT members of *Dilaasa* always played the role of facilitator during decision-making and development of the training programme.

Strategies to Increase Visibility of Domestic Violence as a Health Issue

Apart from *Dilaasa*'s training programme for hospital staff, we felt the need to increase visibility and awareness of domestic violence as a health issue within Bhabha Hospital and throughout the public health system. The following is a summary of strategies implemented by the *Dilaasa* team to achieve just this.

- A pamphlet providing information about the Centre was developed, translated into local languages, and made available at the Hospital's Registration Desk, outpatient departments, inpatient departments and the Casualty Department.
- Posters, calendars, and referral slips have been placed in all the departments of the Hospital.
- A placard has been developed for doctors in each of the out-patient departments, listing the vital and essential signs necessary for doctors to identify cases of domestic violence. These placards are placed in the examination rooms and feature model screening questions, as well as instructions to refer such cases to *Dilaasa*.
- The Hospital's case paper now contains a column titled, 'Referred to *Dilaasa*'.
- The Hospital's Management Information System has been modified to include a field in which Casualty Department Medical Officers are required to keep a daily record of the number of women referred to *Dilaasa* for services report to the Medical Superintendent.
- *Dilaasa* team members visit the Casualty Department every day to screen women who are registered as medico-legal cases.
- The mandatory training to sensitise Hospital staff to issues of gender and domestic violence is a continuing and on going programme. Staff attends a three-hour orientation session, followed by a two-hour follow up training session. New staff members are identified regularly and are informed about their mandatory attendance of the training programme.
- In all of her meetings with senior doctors (honoraries), area councillors, corporators, members of the Public Health Committee and union representatives, the Medical Superintendent underscores the need for and the significance of the Centre. She also encourages them to visit the centre. This has helped in reducing resistance from these quarters.
- Notwithstanding the memorandum of understanding with the BMC for running this project, we expected resistance from the hospital staff. From the beginning, we initiated and encouraged dialogue with the union representatives and those in charge of various departments to elicit their cooperation in the project activities.

I I I . F O R M A T I V E P E R I O D

Work on the project began in August 2000. The project team comprised staff from CEHAT and personnel deputed from BMC. It is led by the Medical Superintendent of the hospital. The main objective of this project was to train the hospital staff on gender sensitisation focussing on their role in responding to violence. It was necessary to involve experts in training the hospital staff. Three experts were contacted and a consultation was organised. While deliberating on the modalities of this training, we took a significant decision. Instead of conducting all the training ourselves, we would train a group from the hospital who would function as key trainers and would then train the rest of the staff. We also felt that some needs assessment must be done at the hospital level to really understand how the system operates.

A few research studies were designed to understand existing hospital systems, the administrative structures and procedures of the hospital and perception of the hospital staff to the issue of violence. (See the section under formative research) This helped us to interact with the hospital staff and establish smooth working relations with them. The findings were useful for us to plan the future path for the project. Several names for the project came up during the consultation. Of these we decided on '*Dilaasa*' as it means empathetic reassurance in Hindustani and it conveyed what the counselling centre would provide for survivors. It was also a word that all the communities understood the same way.

A group of 40 medical and para medical staff was then selected. Two groups were formed with 20 staff per group across the various levels. The first training session took place on October 20, 2000. It was inaugurated by the Chairperson, Public Health Committee and was attended by senior bureaucrats. The trustees of the Ford Foundation also visited the hospital at this point. The entire process of training key trainers almost took a year.

The *Dilaasa* team also went through a process of clarifying perspectives and were imparted specific skills for the roles that they had to play. Gender, gender based violence, sexuality, linkages between violence and health, counselling skills, stress management, documentation skills were some of the components of this training. The team also spent time in surveying the various shelters and other services available in Mumbai. Various protocols used in other counselling centres were studied on the basis of which protocols for the crisis centre were evolved. No counselling was done until these were finalised.

We started providing support to women from April 2001. We needed to collaborate with other organisations for special services like legal aid and shelter. *Dilaasa* began collaboration with Lawyers' Collective for legal aid. Lawyers' Collective recruited a young lawyer to provide legal counselling and aid. Since this lawyer was eager but inexperienced, we had to look for support from another agency. *Majlis* came forward and offered to provide services if women were referred to them. Over a period, *Majlis* agreed to collaborate formally with the crisis centre and a lawyer started visiting the centre once a day. For a year we had two lawyers visiting the centre on two different days. Later, the lawyer from Lawyers' Collective resigned and we now have a collaboration only with *Majlis*.

We also found early on that since the safety of women facing domestic violence was a prime concern the crisis centre also needed to provide shelter facilities. The survey conducted by the team of the shelter homes in Mumbai highlighted both the lack of

services as well as the discriminatory practices of the shelters. Although the agreement with the BMC was that the hospital would provide a separate ward as a shelter for women referred by the crisis centre, the BMC administration refused to make such provision when work on the project started. A number of hurdles were put up: Who would be in charge of the ward; who would take responsibility; the additional expenses that would have to be borne; what would happen if the woman ran away; the case load was, in any case too high and the staff would not be able to manage such a ward; and so on. When the project was reviewed by CEHAT's Institutional Ethics Committee (IEC) in May 2001, it clearly recommended that the centre should establish formal linkages with shelters or provide shelter in the hospitals before starting the centre. It was deemed unethical to provide counselling services to women in violent situations without offering the option of a safe shelter.

The *Dilaasa* team worked out an agreement with two shelters in the city that would provide temporary shelter for 72 hours to women referred by *Dilaasa* irrespective of their rules/procedures/occupancy. The hospital administration too agreed to provide emergency shelter for 24 hours in the form of admission in one of the wards of the hospital when referred by a *Dilaasa* counsellor. This was strictly for women who had medical problems. Although these did not warrant admission, the hospital agreed to accept the women as in-patients for 24 hours so as to ensure their safety.

Apart from legal aid and shelter facility, another important concern was that *Dilaasa* was based in the hospital and would operate only for some hours everyday. There was a need to establish contact with local mahila mandals and other women's organisations that ran support groups for women facing domestic violence. A meeting of women's' organisations was called but only a few attended. Awaze-Niswan(AEN), Women's Centre, Stree Mukti Sangathana, Swadhar, are some of the organisations that extended support to the *Dilaasa* work. It is important to mention here that many women have benefited through participating in the AEN meetings and the AEN workers have been very supportive. Apart form these organisations, we have also sought the support of local mahila mandals supported by WRAG whenever women needed a settlement or support within the community which *Dilaasa* could not provide at all.

Even before the training of key trainers was completed almost 25 women had been referred for counselling in the first four months. The counsellors began to go on ward rounds every day and study the case files of all the patients. The objective was to train the team to read the medical files and understand them as also to demonstrate screening of patients. This exercise was useful for developing a rapport with the staff and create a visibility about the centre. As we began providing services, we realised the need for more training and inputs to be effective. In order to create a mechanism for monitoring the services as well as a space for individual counsellors to share their experiences and learning, case presentation meetings were held. A consultant who was involved in counselling in domestic violence for the past 30 years agreed to provide support to the team by participating in case presentation meetings once a week. This process was formalised from September 2001. The centre was formally inaugurated in November 2001.

On the training front, we finished the training of trainers by August 2001. At the end of the training, we asked the group to volunteer to be part of the core group that would train the rest of the hospital. Of the first group 12 volunteered to be key trainers and the core group was formed. This group then met regularly to discuss and develop training modules and began sensitisation of the entire staff. Groups of 20-25 hospital staff were trained over a period of six months.

In spite of the intensive training one could not see the outcome reflecting in a larger number of case identifications and referrals. Only 111 women had sought support at Dilaasa in the first year (Up to March 2002). The hospital staff came up with these two barriers to identifying cases: 1. Time constraints and 2. High case loads. There were of course unexpressed barriers: Hesitation to ask about violence, reluctance to get into a role that they had so far been trained to avoid, uncertainty regarding the benefits of counselling, amongst others. At our level, we did not question them but responded by suggesting the following: Can you give a pamphlet, card or ask her to go to *Dilaasa*? Or if it was an admitted woman, can you ask the social worker to come and talk to the woman? Between April and June 2000, we reviewed the project work at the team level, with the consultants and the core group and decided to increase the visibility of *Dilaasa* within the hospital as well as in the BMC health system. So cards and pamphlets were made. Pamphlets are given along with the case papers at the registration. The core group that was formed took up the responsibility of the departments of the hospital to keep a constant dialogue with the staff there and sensitise them.

The referrals to the centre increased gradually from 111 in the first year to 204 in the second year to 268 in the third year to 340 in the fourth year. This indicates the gradual process of assimilation of this issue within the system. At the end of two years, we felt the need for follow up training with the staff and so modules for conducting these follow up sessions were developed. Apart from the posters, calendars, pamphlets and cards that had already been distributed, we realised that the doctors in the OPDs were still not asking women patients about abuse. Women who reported abuse were being referred but no effort was made to draw out those who may have been abused but did not report it. We then developed for each of the departments a checklist of signs and symptoms that indicated abuse. These were printed on a placard with a couple of ways in which to ask about abuse and was put up in all the departments. We also began sensitisation of staff from other hospitals of the BMC to increase awareness about the issue within all the BMC hospitals. One-day sensitisation training was held and later training of trainers of four other hospitals was conducted.

Formative research

As reported earlier we conducted a few studies as part of a needs assessment for developing training modules and understanding the lacunae in the system.

In-depth interviews with hospital staff

The *Dilaasa* team conducted in-depth face-to-face interviews with all levels of medical, paramedical, administrative, and labour staff within the Hospital. This was carried out to understand the perceptions of staff regarding domestic violence as a health issue, their beliefs about their roles in responding to victims of violence, as well as current practices. What follows is a brief summary of the key findings culled from interview data.

§ Hospital staff—at all levels—failed to recognize domestic violence as a health issue (despite the fact that they recognize the health implications of violence).

§ Health care professionals perceived domestic violence as a personal and family matter, in which they should not interfere. If presenting injuries contradicted the reported history (for example, a woman who reports having fallen but the injuries indicate assault), they refrained from further probing into the matter or questioning the given history.

§ Health professionals did not see a role for themselves in addressing domestic violence as it was perceived to be a law and order problem requiring intervention by the police.

§ Women who reported having been assaulted were not informed about the importance or purpose of the medico legal procedure.

§ While the staff acknowledged the link between physical violence and physical health consequences, very few understood the psychological dimensions of the negative impact.

§ At all levels domestic violence is not understood as a violation of the rights of women. Rather, it is accepted as a norm and as an integral part of married life.

§ We also found that the hospital staff's approach to domestic violence was one of victim-blaming, in which women are blamed for the abuse perpetrated against them.

§ Hospital staff members had class and communal biases with regard to the occurrence of domestic violence: It was perceived to be more prevalent among the poor, the uneducated, and among certain religious minority communities.

§ Overall, the perceptions held by hospital staff mirrored the mainstream (and therefore sexist) belief systems regarding women's status, women's rights, and gender roles.

Observation at the Casualty Department

The Casualty Department is where all cases of suspected violence are registered. This is why we planned the Crisis Centre close by. To understand existing systems and procedures carried out in the Casualty, as well as the roles and attitudes of staff towards victims of domestic violence we undertook systematic participant observation of staff-patient interactions. Over a period of two weeks, team members sat in the Casualty Department collecting data using this method. A common pattern observed was the way in which the medical needs of patients were immediately attended to, but there was no provision of emotional support or assurance to women facing violence. Doctors were apathetic towards women who faced domestic violence but had not suffered any serious injury.

Study of Medical Records

The *Dilaasa* team also examined and analyzed the medico legal register within the Casualty. The Casualty Medical Officer is required to register all cases of violence and assault as medico legal cases. Case records of both men and women registered in 1999 were studied.

This examination brought to light the improper and incomplete documentation of all medico legal cases, including those cases of gender-based violence. The study revealed that various types of mandatory information were not being recorded. Due to this lapse in documentation, the team found it challenging to determine whether particular episodes of violence were indeed cases of domestic violence. Based on available data, the percentage of assaults among men and women appeared the same. With regard to the nature of the injury and assault, the available information indicates that assaults on women were likely to be acts of domestic violence. Women were more

likely than men to be assaulted by kicks and bites, and suicide attempts among women were three times that among men.

Based on the above three research activities—in-depth interviews with hospital staff, observation of the Casualty Department, and examination of medico legal records—a number of specific needs were identified with regard to the training programme. It was determined that staff required education and awareness-building interventions in the following areas: domestic violence as a public health issue, the relationship between gender, violence and patriarchy, the importance of gender sensitivity in health care service delivery, the relationship between victimization and health status and the role of the health care professional in caring for patients facing domestic violence.

Survey of shelters

We undertook a rapid survey of shelters in Mumbai so as to know their policies and to create a database that would be updated regularly. The survey showed that the admission policies of most shelters are highly conditional and selective. Restrictions on the admission of children—particularly male children and mandatory HIV testing are some of the conditions for admissions into many of the city's emergency shelters. Only one shelter in all of Mumbai accepts women unconditionally.

These studies shaped the project's activities in many ways. While they were extensively used for developing training modules, the team's understanding about the changes that need to be made in the system and the protocols that need to be developed were based on these findings.

IV. COUNSELLING MODEL AND STRATEGIES

The *Dilaasa* Crisis Centre provides counselling to women facing domestic violence. Operating within a feminist perspective, the Centre ensures immediate psychological and social support to women to enable them to effectively cope with and manage crisis. Emotional support so essential to women during their first visit to the hospital after an episode of violence is offered. The primary goal of counselling is to validate women's feelings and experiences, support their decisions, respect their intelligence, and mitigate feelings of inferiority, powerlessness, and disrespect.

The Centre's operation and functioning is based on the following principles. **The primary principle** is that victims cannot be blamed for the violence they face. Every woman who pursues formal redress is essentially challenging the structures and power of patriarchy. **Our second principle** is that domestic violence cannot be dealt with in isolation; rather, an understanding of social structures and inequities organized by caste, class and community is an essential component to the counselling process. **Our third principle** is that any effort to bring justice for those in society who are disadvantaged must not ignore the issue of violence against women; social justice cannot be truly achieved until the linkages between different forms of exploitation and oppression against different groups of people are identified, understood, and broken. **Lastly,** efforts undertaken to eliminate domestic violence should be concomitant with the broader goal of ending all types of violence in society. We view our work as a step in the direction of freeing all people from the culture of violence and nurturing the culture of peace.

Features of a hospital-based crisis centre

- There is a marked difference between the mindset of a woman who steps into *Dilaasa* and another who may go to any other counselling centre. A woman coming to *Dilaasa* has been referred to the centre by a hospital staff when she comes to the hospital for treatment or has accompanied someone. Most often she is not aware of the nature of services offered and is not prepared to talk about her personal problems. On the other hand a woman who approaches any other agency- a counselling centre or the police- to seek redress, has made up her mind to talk about her private oppression and the violence. This specific mindset of the woman who steps into *Dilaasa* is a distinct factor, which the counsellor has to consider

- The counsellor meets the woman in the ward after it has been determined that she may have been subject to domestic violence. Sometimes, she is in severe pain and not in a condition to talk. Coordinating with the hospital staff therefore becomes of prime importance here considering the fact that her health condition required admission. In such cases there is high probability of severe violence.

- The time factor is a challenge. Counselling sessions at other agencies are long drawn and frequent before arriving at any strategies. For arriving at long-term alternatives frequent sessions are needed. The women who come to *Dilaasa* are not able to sit for a long time - 45 minutes is the average duration of a counselling session as they have come out of the house only for treatment. Their follow-up therefore depends on their first impression of the counselling session. They usually couple their medical follow up with a *Dilaasa* follow-up and so time management remains a challenge during follow-up sessions also.

- The hospital is located in an area that has a larger working class Muslim population. They come from economically disadvantaged section. Special care needs to be taken before seeking legal and police redress in case of minority women due to the current attitudes towards the minorities. All of us have to guard ourselves from common biases held against this community. Bhabha hospital and in turn *Dilaasa* is uniquely placed to render much needed relief to the minorities by being level headed, humane and making the relevant interventions.

- By and large it is the lower socio-economic class that accesses the public health system. There is a strong negative bias against them too. Through the crisis centre work, there is an opportunity to humanise the system. That health care is the right of the patient is a concept that needs to be integrated at all levels of the hospital system.

Counselling Methodology, Guidelines, and Procedures

Since *Dilaasa* was the first such centre in a
public hospital, the team engaged in researching policies and processes followed by other counselling centres, learned through dialogue with those running counselling centres, developed the policies and procedures for the centre and established linkages with other organisations working on domestic violence and related issues.

What happens when a woman comes to *Dilaasa* for the first time?

Referral to the centre and expectations

Women approaching the Crisis Centre are often referred by a health care professional from one of the outpatient departments or the Casualty Department of the Hospital, after seeking and receiving medical services there. Many are simply told to come to *Dilaasa* and thus, they are not aware of the nature or range of services provided here. In some instances, counsellors have been mistaken for doctors. Women victims who have been admitted to the inpatient wards often meet with counsellors during their regular screening rounds. In these cases, they are informed about the services offered at the Centre. However, women admitted to the wards may be in severe pain or suffering serious injuries as a result of the violence. Some women are also referred from outside the hospital—by individuals, former clients who have previously sought help from *Dilaasa*, and other organisations or NGO's.

As a result of the way in which many women first come in contact with the Centre (i.e., not self-referred with a specific objective or expectation in mind) and the fact that it is based in a medical setting, women are often not able or willing to openly discuss their histories of violence. Women coming to *Dilaasa* do not identify the Centre as a women's organisation, but as a department of the hospital system. Therefore, they coordinate their medical visits with their follow-up counselling sessions.

First Step: Rapport Building

The initial interaction between the counsellor and a woman consists of sharing information about the Centre and its activities, followed by an assurance that information shared by women is kept strictly confidential. The focus of the first visit is on building rapport and trust. Attempts are made to breakdown the formal barrier or distinction between 'service provider' and 'client' and put women at ease.

As the counselling session can be lengthy, women are asked to first complete all their hospital-related work (such as obtaining medicines or diagnostic tests) and assistance in accessing those services or negotiating with medical staff is provided if needed. When a woman reports to the Centre immediately following a physical assault, she is escorted by the counsellor to the Casualty Department for treatment and MLC registration.

Emotional Support

The most important message to be conveyed to women during the first counselling session is that they are not to be blamed and should not blame themselves for the violence they have faced and continue to face. Examples of excuses commonly used to justify violence—such as not serving food on time, coming home late from work, or visiting with friends and family—are discussed. The counsellor discusses the concept and structure of patriarchy and identifies violence against women as one of its manifestations. Details of the cycle of violence and how it can be broken are also shared with women.

For women who have attempted suicide or are contemplating self-harm, attempts are made to help them realise the will to live. Counsellors help women to cope with feelings of guilt over the attempt, anger towards the abuser and feelings of hopelessness.

An important aspect of the counselling process is tapping the women's own resources and strengths. Thus, in addition to helping women identify informal support systems on which they can rely, coping mechanisms they have and can employ in the future are thoroughly explored. As any incident of violence results in physical and mental debilitation, many women come to the Centre on the verge of an emotional breakdown.

Safety Assessment and plan

During the woman's narration of her history of violence, counsellors express grave concern over the woman's safety. A series of yes/no questions are used to assess the severity and frequency of violence, changes in the nature of violence over time, as well as the woman's perceptions of her safety. The exchange is used to assess whether or not it is safe for the woman to return to the violent home. These issues are discussed with women and if it is determined that alternative shelter is necessary, different options are explored. The presence of informal support systems—such as those provided by family, friends, neighbours, colleagues, and employers—is also explored during this time. If a woman does not have any informal support, then information about temporary shelters is given. For some women, 24-hour emergency shelter at Bhabha Hospital can be provided. Such a provision is only available to women who have a medical problem. In these cases, women are admitted to an inpatient ward, so as to give her some time to regain her strength, as well as some space to reassess her situation and decide her course of action. Women are encouraged to take advantage of these options. However, if a woman chooses not to avail of these facilities, her decision is respected and the counsellor works with her to develop strategies to protect herself within the violent home.

Registration of complaints

Many women are reluctant to register a formal complaint against the abuser as they fear fresh and more severe incidents of violence following their return to the violent home. Counsellors stress the importance of filing a non-cognisable complaint (NC), which involves giving a statement about the episode of violence. In this case, the police officer only records the statement and does not take any action against the abuser. The NC is crucial, as it provides evidence of the violence she has faced without disclosing to the abuser that she has reported the violence. Women who want formal action to be taken against the abuser are advised to file a First Information Report (FIR).

Legal counselling

Women are also provided detailed information about the laws related to custody, divorce, maintenance and provision of section 498A of the Indian Penal Code and the ramifications of such action. Women who have opted to pursue legal action are connected with a lawyer from an organisation called *Majlis*, who visits *Dilaasa* once a week. The most frequent legal assistance needed by women involves the processing of an injunction order, petitioning for maintenance and, occasionally, filing for divorce.

Referral to other agencies

For some women, individual counselling is not effective enough and they feel the need to connect and speak with other women who have also been victimised by domestic abuse. The purpose of group counselling sessions is to eliminate feelings of loneliness and isolation. Women requiring such an intervention are referred and accompanied to organisations that facilitate such group meetings, such as Awaaz-e-Niswaan and the Women's Centre. Women are also given information about available skill building courses, trusts providing monetary relief for educational and health purposes and are referred to relevant agencies for social support.

Challenges in finding temporary shelter

Shobha came to the centre in her third trimester of pregnancy. She suffered from epilepsy. She was facing severe physical abuse from her husband and her mother had brought her back when she witnessed her husband's brutality in beating her. Her husband later burnt their two sons alive. Her natal family is poor and are able to barely survive. Her mother put her in an institution for delivery where Shobha was to give up the child for adoption. During her stay in the shelter she witnessed one of the staff beating an inmate and she ran away with another inmate who was registered at *Dilaasa*. After she came to the centre, efforts were made to contact her mother. Although her mother came to the centre, it was not possible for Shobha to live with her because of financial reasons as well as the fact that she needed medical attention. Shobha was then admitted in the hospital for emergency shelter for two weeks while efforts were made to find a shelter for her. Not a single shelter in the city of Mumbai was willing to admit her because of her medical history. The counsellors spent hours trying to explain her condition but nobody wanted to take a risk. None of the shelters seemed to have any doctor on call. Finally through 'Children of the World" which takes children for adoption, she was admitted to a hospital until she delivered the baby.

Plan of action

At the end of the counselling session, the counsellor and the woman reflect on her life story and plan a future course of action—whether it is coping with the trauma associated with the violence, emotional healing, or obtaining services from other agencies (such as shelter and legal aid). Women are encouraged to follow-up at the Centre and to visit whenever they feel the need. Care is also taken to ensure that women leave *Dilaasa* with something concrete they can utilize to end the violence in their lives and/or mitigate the negative effects of the violence.

Follow-up Sessions

Subsequent, or follow-up sessions with the woman commence with exploring the woman's reasons for their visit. She is encouraged to tell the counsellor about any recurring incidents of violence. The importance of the woman's physical and mental well-being is reiterated and care is taken to build her confidence and offer constructive support. The woman's safety plan is reworked if she has reported fresh incidents of violence or difficulty in implementing strategies developed previously. Women reporting fresh incidents of violence are also taken to the Casualty Department to register an MLC and for any necessary medical care. By the second counselling session, women are usually more comfortable and have developed a degree of rapport with the counsellor. This second session also provides an opportunity to probe into issues not explored during the previous visit. Women may express new needs during the follow-up sessions, ranging from help in obtaining employment to negotiating for cessation of violence with the abuser in a joint meeting facilitated by the counsellor.

Joint meetings are used to create a non-violent space where women can engage in dialogue with their abuser/s to negotiate for the cessation of violence and assurance of their safety. Preparation for such meetings entails taking a woman through a mock joint session and role plays, helping her articulate expectations of the meeting, and developing strategies for negotiation. Counsellors are required to thoroughly understand the woman's life, family history and are responsible for preparing women for such meetings. Counsellors are expected to be facilitators in such meetings.

Documentation

An Intake Form is used by counsellors for every woman coming to the Centre. It serves to document the counselling process and record basic socio-demographic information, contact information, the woman's family structure, her history of violence, a safety assessment, the impact of violence on her health, expectations expressed, coping mechanisms employed in response to the violence, as well as the counsellor's impressions and feedback from other project team members regarding the way in which the case is being handled. An address or telephone number on which women can be safely contacted is also an important feature of this form, as it enables the counsellors to communicate with women when necessary without any fear that the contact would endanger the woman. The information related to the history of violence is normally added to the Intake Form after the counselling session. Brief notes are maintained by the counsellor during this process, as focussing too heavily on completing the form can be disruptive to the counselling process.

Challenges in Counselling

We have identified a number of challenges from our experience of providing crisis counselling and emotional support to women in distress during the last three years. Each of these challenges and realisations carry certain implications for the methods and framework we use in our work with victims and survivors. We believe that other hospital based crisis centres would have to deal with most of them. These issues are summarised below.

- For women in the 15—25 years age group, it is distressing to observe the extremely high intensity of violence as all these marriages are very young. Women have reported that the onset of violence began almost immediately following their marriage. This is an alarming finding. The usual stressors associated with any new marriage, coupled with the trauma of domestic violence, create a debilitating and numbing effect on the women. Counselling has to be geared towards helping women acknowledge, come to terms with, and deal with the fact that she is being abused by her loved one/s.

- The majority of women coming to *Dilaasa* live in marital relationships and are facing severe violence. Most women want to remain in the marital relationship and want the violence to stop. There is a need to have a family and uphold it. There is little acceptance of single, separated and deserted women within society. This puts further pressure on women to continue to live in marital relationships despite the violence. It limits their capacity to look for alternatives. An understanding of the meaning and significance of marriage in our society is important for counsellors to respect women's decisions and provide continuing support.

- Even when the violence is severe and women perceive a threat to their lives, they often choose to return to the violent homes. This is the case even when admission to a temporary shelter is available. Counsellors have found it challenging to simultaneously communicate the seriousness of the safety threat to women while also being comfortable with their decision not to avail of alternative shelter.

- Though the objective of joint meetings is to provide women with a platform to articulate their demands to the abuser/s and negotiate for non-violent conditions, it is imperative for counsellors to guard against playing the role of an arbitrator. Joint meetings therefore need to be called after adequate counselling to strengthen the woman's capacities to negotiate for non-violence.

- While legal aid and information on rights to maintenance, custody of children and property are sought by many women, these women are less likely to follow-up at the Centre. This indicates that these women may feel discouraged by the limitations of the judicial system in ensuring justice. Counsellors should make diligent attempts to contact these women when they cease visiting the Centre regularly. Non-legal strategies for redress should also be further explored.

- Working with the police system remains a significant challenge due to their unsupportive and victim-blaming attitudes with regard to gender-based violence, as well as their biases against minority communities, especially Muslims. Typically the police respond arbitrarily to complaints of domestic violence, despite efforts to sensitise them to the issue. However, while they have refused to register complaints in some cases, in others they have entered into reconciliation processes or have threatened the perpetrator to stop violent behaviour. For Muslim women, accessing

appropriate police support is particularly challenging due to a number of factors. In their experience Muslim men are unfairly and more brutally abused by police than their majority counterparts (making Muslim women more hesitant to report their abusers) and Muslim women are more susceptible to derogatory comments and unequal access to services.

- Most shelters have rules that discriminate against women with certain health conditions and age, and do not admit children. This becomes problematic as women facing severe violence need temporary shelter for keeping themselves safe. Destitution is a consequence of severe violence and the paucity of available resources makes any intervention with such women, complex.

- At the centre, through counselling, expectations of women are raised but there are not enough resources to meet their expectation. Very often, women say - **"***Why should I quit home when my husband is violent" "he has to be prevented from it" "I want justice", "make him understand it***".**

- Almost 20 percent of women coming to *Dilaasa* have come for counselling after an attempt at self harm. Women with suicidal thoughts arising out of domestic violence have special counselling needs and the staff had to therefore evolve strategies to address this problem. A simple communication pamphlet was devised for such women. It contains positive messages in the form of a story and is given at the end of the counselling session. Related to this is the other issue of reaching out to women who have a diagnosed mental disorder and are facing domestic violence. For both these aspects, a multidisciplinary approach is required where the counsellor, the psychologist and psychiatrist work in tandem. This is an area that the Centre has to take extra efforts in order to reach out to women.

Challenges in counselling

Anandi is a 47 year old from a middle class family. She was married to her sister's brother in law. Her husband turned out to be a womaniser. One day he brought a woman home on the pretext that she was in distress. She continued to live them. Anandi had no say at all on this. Even though her sister knew about the other woman staying in the house, nobody took any action. Anandi did not tell her brothers about this as she was ashamed and felt that it would cause unnecessary tension. She faced violence from both her husband and the other woman. Anandi had two children. Her husband and the woman even tried to poison her once. That's when she came in contact with the police and a complaint was registered. Following this her husband threw her out of the house and filed for divorce on grounds of cruelty. At the family court, her lawyer and counsellor advised her to go in for a one-time settlement/compensation and agreed to divorce by mutual consent. She was also advised to withdraw the criminal case against her husband and to give up claims for custody of the children. The lawyer then tried to settle her with various clients and shelters. But Anandi was depressed and unable to settle down anywhere. The frequent moves led to deterioration in her mental and physical health. Today she stands shelter-less. Her medical condition and age prevent her access to any shelter. With no objective data (natal and marital family have totally abandoned her) the psychiatric department is unable to establish diagnosis.

Monitoring and ensuring quality in counselling

Every week there is a case presentation meeting of the team in the presence of a consultant, who has long standing experience in the field of domestic violence counselling. The counsellor presents the details, states her impression and interventions and future plan that she has for each of the women that she counselled in the last week. The group discusses this and the meeting is documented and suggestions followed up with the woman in the next follow up. The process achieves the following:

1. The counselling process is well monitored

2. The counsellor gets team feedback to enhance her skills.

3. It creates awareness in the team regarding the profile of women who come. It broadens their knowledge and skills.

4. It makes it easier to conduct follow-up session even when the counsellors are changed. It also strengthens team spirit.

5. During these meetings the counsellors are encouraged to share their emotional and ethical dilemmas. The effort has been to create a space where confidentiality is maintained and is non-judgemental so that the team is able to share their innermost feelings. This we believe is critical for the growth of any counsellor working on domestic violence as it is extremely demanding at the psychological level.

These meetings therefore provide space not just for discussing strategies for individual women but also for counsellors to unburden their pressures. It also helps counsellors to talk about their own lives in terms of their own struggles and contradictions if any. We believe that it is important to be at peace with oneself to be effective while reaching out to women
in violent relationships.

Besides the weekly meetings, the consultant sits through the individual counselling sessions and provides a feedback. Both the consultant and the project in charge are available to the counsellors for consultation, discussion on possible options or ventilation. Basically, all care has to be taken to help the counsellors feel free to share any of their problems at any stage in the counselling.

In addition to these strategies the counsellors are encouraged to attend workshops, discussions, seminars and training programmes on women's issues. This ensures the counsellors' growth and professional development continuously.

[The sections here are based on the documentation done by Aruna Burte, Consultant, and the Counselling Centre Report, prepared by the *Dilaasa* team in 2002.]

A need to link up with other agencies

Shama is a 28-year old who had attempted suicide. Her husband had asked her to leave the house with a son who was mentally challenged and refused to give custody of either of the other two children. She had been labelled 'mad' by her marital family as she would break down frequently and cry. Her husband would demand sex anytime without caring to know if she was tired or there were children around. Her mother-in –law would find fault with whatever she did and abuse her verbally all the time. After being thrown out of her marital home, Shama and her mentally challenged son were living with her parents. Everybody felt that she was not being accommodating making the necessary and normal compromises in living with her husband and so he had been thrown her out. She felt lonely and sad and was driven to commit suicide. After providing emotional support to Shama, she was referred to a support group run by a women's organisation. Shama attended the meetings there and it helped her to connect to other women who had faced similar misery and violence. This gave her the strength to move on in her life. She picked up a job and decided not to fight for the custody of the children till she became independent. Today, she has moved out of her natal home and has managed to gain custody of her youngest child.

V. TRAINING MODEL AND STRATEGIES

Evolving a model for training

The need to sensitise all hospital staff to the issues of gender and violence prior to setting up and implementing services at *Dilaasa* was clearly identified during the project planning stages. This sensitisation was deemed necessary in order to garner the support of the hospital for the Centre, ensure referrals, increase awareness on the issue among staff, and to help staff to begin to recognise and identify *Dilaasa* as an integral part of the Hospital.

Three experienced individuals in the areas of gender, health and violence were recruited to facilitate this sensitisation process. They were: Manisha Gupte, Ms Radhika Chandiramani and Renu Khanna. Manisha is the co-convener of Mahila Sarvangeen Utkarsh Mandal (MASUM), a rural women's organisation based in Pune district. She has been part of the women's movement and has undertaken research, training, activities related to issues of health and sexuality. Ms. Radhika Chandiramani is a qualified clinical psychologist and Executive Director of Talking About Reproductive and Sexual Health Issues (TARSHI), a Delhi-based NGO that operates a help line for the public addressing needs related to sexuality and reproductive health. Renu Khanna is a founding member of SAHAJ and has extensive training experience on gender, violence, and sexuality issues. She is also involved in a collaborative project with the BMC—the women centred health project that aims to sensitise the health system to women's health issues and improve the quality of primary level reproductive and sexual health care service system of the BMC.

These three individuals were thoroughly oriented to the infrastructure, policies and procedures of Bhabha Hospital. While discussing the various methods of training hospital staff, it was concluded that the most efficient, strategic, and participatory way of training the entire hospital staff (comprised of 882 individuals) was to recruit a group of select staff members who would be trained as trainers and then form a training team that would then conduct the sensitisation training for the rest of the staff of the Hospital. The Medical Superintendent selected forty staff members who held permanent positions within the hospital and demonstrated commitment to their work. These individuals were trained as the *Dilaasa* key trainers and included doctors, paramedics, nurses, as well as some staff from the administrative branch.

The resource persons suggested that a needs assessment be conducted first. Such an assessment would allow the resource team to identify the strengths of the staff, gaps in their knowledge, their current understanding and perceptions of gender and domestic violence, as well as their current responses and practices with regard to victims of domestic violence. A few small studies were conducted before the commencement of the key trainers' programme. The content of the training sessions was evolved through discussions and exchanges over the findings of the needs assessment among the resource persons and *Dilaasa* teams members.

The process of training the key trainers almost took a year, with each of the three resource persons taking responsibility for specific topics and sessions. Two groups, each consisting of 20 hospital staff members, were constituted. Each group was composed of both medical and paramedical staff. There were two main reasons for

composing the groups in this manner. First, if groups consisted of only doctors or of only nurses, the hospital work would be affected as all staff from the same level cannot be deputed for training at the same time. Second, in hospital hierarchies doctors are at the top, followed by nurses, and then the labour staff. By mixing the groups, we aimed to break some of the barriers that exist between different levels of staff and challenge the hierarchical system. This we feel is a first step in challenging the low social hierarchical status accorded to women, which operates even in health care settings. Each group gave themselves the names *Pragati* (progress) and *Prerna* (inspiration), respectively evolving their own identities.

The training was conducted as seven full-day training sessions over a period of one year depending on availability of resource persons and hospital staff. The process was documented. The trainers administered pre and post-tests to evaluate the impact of the sessions and of participants' responses.

Sessions Chart

	Topic	**Objectives**	**Methodology**
Day 1	**Domestic Violence-an orientation**	§ To break the silence around violence. § To introduce the concept that domestic violence is a public health issue. § To share information about *Dilaasa* as a hospital based crisis centre. § To motivate the group to become key trainers.	Individual exercise, discussion.
Day 2	**Gender**	§ To create awareness about the difference between sex and gender. § To sensitise participants about the manifestations of gender. § To create awareness about patriarchy and power relations.	Game, lecture, case study
Day 3	**Violence and role of health care providers**	§ To create awareness regarding the role of health care professionals in dealing with domestic violence. § To train them to care for women patients facing domestic violence.	Case study, role play
Day 4	**Counselling**	§ To impart skills required by key trainers to communicate with women patients who report abuse and maltreatment. § To help them gain an understanding of the concept of counselling and the principles involved in it.	Brainstorming, individual exercise, role play, lecture
Day 5	**Role of trainer**	§ To understand the principles of adult learning. § To help participants gain an understanding of the different methods involved in conducting a training session.	Individual exercise and sharing, group work,

Day 6	**Communication skills for trainers**	§ To help the participants understand the methods, principles, roles and tasks involved in conducting training sessions. § To gauge the preparedness of the participants in conducting training sessions.	Individual exercise and sharing, group work and reading
Day 7	**Gender-based violence and role of health care professionals**	§ To understand gender based violence and its manifestations. § To understand the health consequences of violence against women. § To bring about the realisation that violence is a public health issue. § To explore the role of health care providers in dealing with gender based violence. § To think of an integrated and department wise plan to address the issue of violence against women.	Group discussions, Case studies, Lecture, Group work, Transparencies.

Core group

Following the conclusion of this training programme, 12 of the 40 participants showed keen interest in conducting on-going training sessions for the entire hospital staff. These 12 individuals thus emerged as the core group of 12 key trainers. Core group members met regularly and developed a three-hour module for orienting staff to domestic violence as a health issue and to gender issues in health. This process took six months with meetings twice a month for about an hour each. A three- hour module that consisted of two sessions was finalised. The first session was aimed at developing an understanding about gender, domestic violence and types of domestic violence through role-plays and case studies. The second session was aimed at building capacities amongst the staff for responding to patients sensitively. This was through role-plays.

Following the core group's implementation of six orientation sessions, a meeting was arranged with Manisha Gupte, during which key trainers shared their experience thus far and expressed some of their concerns about handling discussions, confrontations and specific questions posed to them during the training sessions. Manisha discussed various strategies they could adopt when certain issues are raised during the training. The orientation module was revamped following the initial sessions and has now been finalised after testing it with a number of groups.

Beyond the hospital

§ In addition to training staff of Bhabha Hospital—the institution where *Dilaasa* is located—orientation and training of staff from other BMC hospitals has also begun. This training programme focuses on the health consequences of domestic violence and is designed specifically for the following posts in each hospital: Medical Superintendent, Senior Medical Officer, Matron and Female Social Worker.

§ As *Dilaasa* is a hospital-based centre, the staff has to frequently liaise with the police on behalf of women facing domestic violence. The police and health systems must work in tandem in order to establish legal evidence documenting cases of violence. Training is also provided to police officers of the nearby police stations.

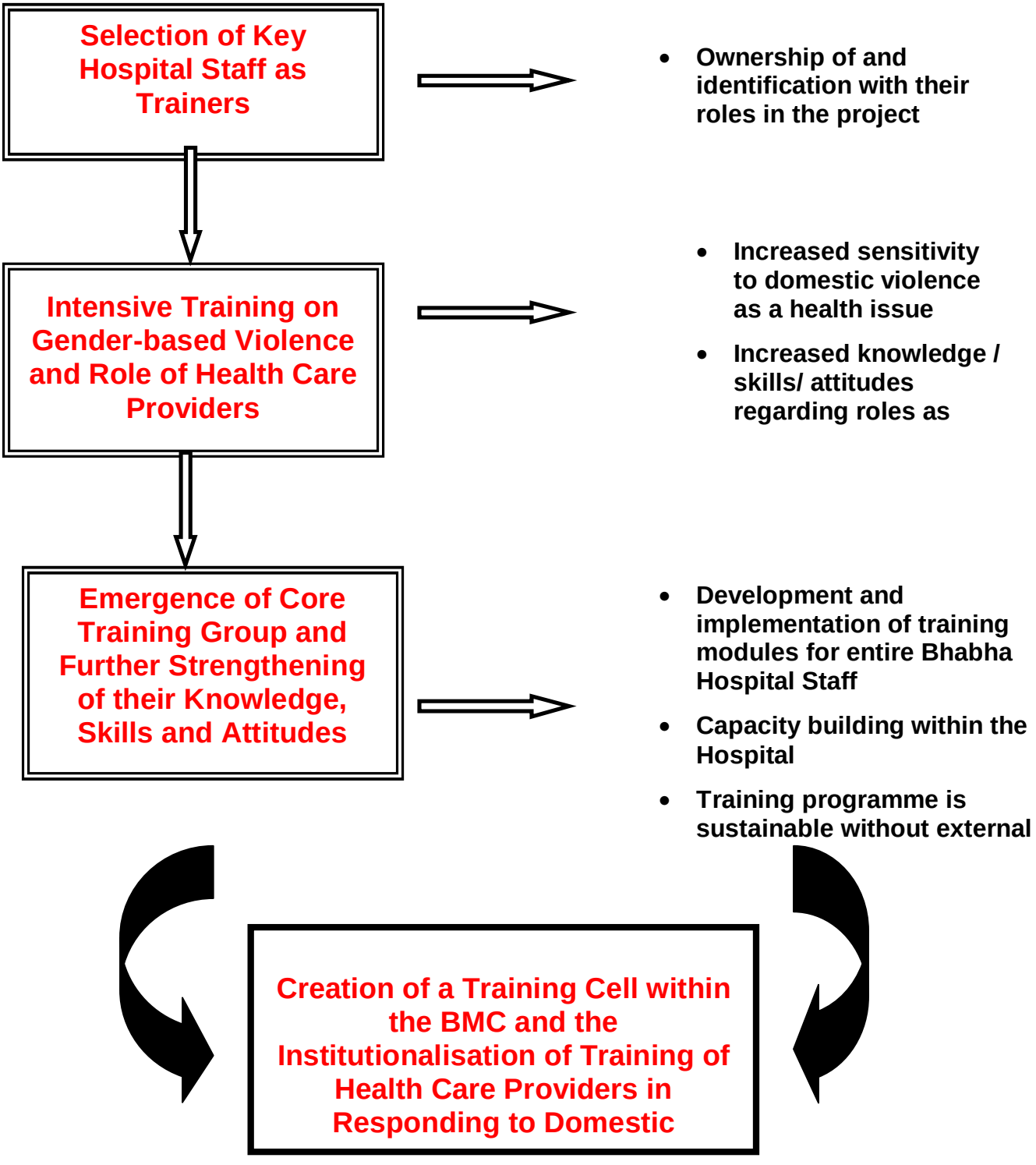
Challenges in training

We faced a number of challenges in trainings sensitising hospital staff to issues they are normally not required to consider. These specific challenges are presented below.

- Medical professionals at the hospital are focused on specializing in particular curative branches of medicine. This means that they are fully occupied and their interests generally lie outside the areas of prevention and the social aspects of health. They are not trained to view health and health care from a social perspective. There is a dual control over them–the administration and the honoraries.
- Resident Medical Officers at Bhabha Hospital have a six-monthly posting, which means that the time frame in which we can sensitise them and influence positive changes in the way they respond to victims of domestic violence is short. Similarly, medical interns are assigned short duration posts at Bhabha Hospital. They cannot make the time to attend even a short training session as their prime and time consuming responsibility is running the OPDs and wards.
- Due to heavy work and patient load, providing the most basic medical care is the priority of the staff. The population served by the hospital is eight lakhs. This creates great demand on the system and human resources.
- The processes of sensitisation, awareness building, and behaviour change are lengthy ones. Therefore, mandatory participation in one or two training sessions is not enough to create an impact.
- Generally, medical professionals do not recognise domestic violence as a public health issue
- There is no system for ongoing training.
- Furthermore, the training programme must keep pace with the high staff turn over and transfers at the Hospital.
- The Hospital is closely linked to maternity homes, dispensaries and health posts. The staff working at these levels needs to be trained and a referral system for survivors of violence needs to be put in place. But these fall under another system within the BMC and we have found it very difficult to engage with those concerned on these matters.

The flow chart below is a visual representation of the model utilised for implementation of the key trainers and medical staff training programmes. We are grateful to Manisha Gupte and Renu Khanna for the concept and inputs through the entire process of training.

The *Dilaasa* Training Mode



VI. LESSONS LEARNT AND RECOMMENDATIONS

From our experiences of providing services at the Crisis Centre over the past three years and attempting to integrate the project and issue of violence against women in the public health system, a number of insights have become clear. These are summarized below.

Study of case documentation

A retrospective study of women registered with *Dilaasa*—utilising secondary data recorded by counsellors during sessions in women's case files (referred to as case documentation data) — was conducted in order to understand the socio-demographic background of women accessing services at the Centre, as well as the patterns and types of violence perpetrated against them.

The findings of this study indicate that young women constitute a significant proportion of all women approaching the Centre. Forty percent of women were in the 15—25 years age group, followed by 35 percent in the 26—35 years age group. Other findings include: the majority of women (60 percent) are of the dominant Hindu community; 50 percent of women had completed their secondary education; the majority of women were not employed and amongst the employed, most worked in the informal sector (such as domestic work). Over 70 percent of the women who sought counselling were married and currently living within the marital relationship. Only 5 percent were unmarried. It is noteworthy that among married women, 33 percent were married for less than five years while 20 percent
were married for 6 -10 years.

The most common forms of violence experienced by women were physical and emotional in nature. Twenty-nine percent of women coming to *Dilaasa* had come to the hospital reporting assaults, followed by 20 percent reporting the consumption of poison (suicide attempt), and 16 percent reporting reproductive health complaints. While these were the reported health complaints for which women sought specific medical treatment, women also reported other significant health problems—aches and pains, asthma, frequent fevers, loss of appetite, anxiety, insomnia, and depression.

Women availing of *Dilaasa* support are more likely to come in the morning, which is the time the outpatient departments are open. They are also likely to follow-up during the early part of the day. They couple their visits to the crisis centre with their visits to the Hospital, where they seek health services for themselves and their children. 50 percent of the women registered at the Centre have come for a follow-up visit at least once.

This analysis has been done annually. It is interesting to note the gradual increase in the number of women seeking support at *Dilaasa*. In the year 2001 there were 111 women, which increased to 204 in 2002, 268 in 2003, and 340 in 2004. This increase indicates that the recognition of domestic violence as a health issue within the health system is taking place slowly.

Evaluation of Hospital Staff Training Programme

In order to assess the impact of *Dilaasa*'s efforts to sensitize and train staff of Bhabha Hospital, as well as other peripheral hospitals, pre- and post-surveys assessing changes in knowledge, attitudes and beliefs have been developed and administered, as have post-training surveys assessing participant's satisfaction with and perceptions of the relevancy of the programme. These evaluation tools are implemented and data analyzed on an on-going basis in order to improve training programme structure and content. Overall, the staff express high satisfaction with the ways in which the trainings are conducted—the methods used, the content, and the expertise of the training facilitators. From their responses it is evident that there is an increased understanding of domestic violence, its forms, prevalence and causes. The health consequences of domestic violence are also retained. They also express their role in referring women facing domestic violence to *Dilaasa*. However, considering the slow increase in referrals to the centre by staff, it is apparent that short-term training is not adequate to effective permanent and significant behaviour change among health care professionals. What we have realised is that although the staff participates enthusiastically and also recognises it as an important issue to be addressed by them, there is some resistance to actually getting into the role of screening and actively referring women.

Identification of abuse and referral to *Dilaasa*

Amma was referred to the Occupational Therapy Physiotherapy (OTPT) department by the orthopaedic department for the injuries that she had sustained. Amma had reported that she had fallen and hurt herself. At the OTPT she had received therapy for her hand and shoulder for a week. During this period, the physiotherapist found time with her alone and told her about *Dilaasa* and what it does. She then asked her if she would like to go there. Amma said, "No, I do not need it". The following day, the physiotherapist asked her how she had sustained her injuries. Amma repeated the same story about a fall. The physiotherapist suspected abuse but did not want to probe further as she feared that the woman might not come back for treatment. She then asked one of the *Dilaasa* counsellors to come to OTPT department and speak to her. Amma then talked about the abuse she had suffered and subsequently sought *Dilaasa* services.

Ria was admitted in the Intensive Care Unit as she had consumed poison. She refused to tell anyone about the nature of the poison or what it was. This was a barrier to her treatment. The sister in charge asked all her family members to leave and spoke to her alone. She promised Ria confidentiality and also informed her that she could speak to a counsellor in the hospital and seek help for whatever problem she was facing. She told her that whatever she shares with her and the counsellor would not be disclosed to her family. She also explained to her that it was important for the doctors to know what she had consumed so that she could be provided appropriate treatment. Ria opened up to her and also spoke to the Counsellor.

Sheela was brought to the hospital by her family members after a severe beating. At the Casualty, the doctor asked her to register a police complaint and also go to *Dilaasa* department. He told her to tell the workers all the details of the abuse so that they could help her. He told her that she has to seek support from *Dilaasa* as mere treatment given by him will not help her. Sheela came to the centre the very same day.

Counselling Impact Study

Over a period of four months in 2003—2004 the *Dilaasa* team undertook a qualitative research study to assess the effectiveness and impact of crisis counselling implemented at *Dilaasa*. Specific objectives of the study were: to assess the impact of the crisis intervention model utilized by *Dilaasa*; to test indicators of counselling impact and effectiveness; to understand women's perceptions of their experiences in accessing services at *Dilaasa* from women themselves; to understand the processes and pathways by which counselling strengthens women's capacities to cope with violence; and to gain insight into the effectiveness and appropriateness of hospital-based domestic violence intervention programmes. In order to reach these objectives, qualitative, in-depth interviews were conducted with: (1) women currently accessing services at *Dilaasa* (*current programme participants*), (2) *former programme participants* (women who no longer access the Centre, whose cases are considered "closed" by Counsellors and who received the support for which they came to *Dilaasa*), and (3) women who have come to the Centre once but have not returned for follow-up visits (*non-returning programme participants*).
A total of 27 women participated in this study, of whom 19 were current programme participants, 5 were former programme participants, and 3 were non-returning programme participants. Preliminary findings based on the data analyses carried out thus far include the following: Women in general have concretely benefitted (improvements in mental and physical health indicators) from counselling and social support services; women have said that the setting of the Centre within the hospital makes it easier for them to seek counselling; The indicators developed for effective counselling appear to be relevant to women's experiences at *Dilaasa* (i.e., the non-judgemental attitude with which counsellors listen and speak, the messages women receive); Several women expressed the desire for *Dilaasa* to conduct outreach and community-based services; While the *current programme participants* find the individual-based counselling a great strength / support, there is an expectation from women in general that the Centre do preventive work; Services currently provided by *Dilaasa* do not address the social, or root causes of domestic violence; The majority of women accessing services are living in abusive marital relationships and due to lack of control over resources and opportunities, are, in general, unable to break the marital relationship; among *non-returning programme* participants, women do not return to the Centre due to a variety of reasons (limited time, restricted ability to leave house due to abuser, and dissatisfaction with the limited array of services offered by the Centre)

As *Dilaasa* is the first hospital-based crisis centre in India for women facing abuse, insight into the experiences of women accessing its services and documentation of the impact those services may have are critical. While formative research has been conducted to aid in the development and design of the programme, to date, we have not implemented any evaluative or outcome-focused research activities. The results can be used to establish standards of care and best practices for addressing domestic violence both (a) through crisis counselling and (b) within the public health system. This study will make a significant contribution to the field of public health and violence prevention and will contribute to the social understanding of the situation of women facing violence.

Recommendations

1. Through our interactions with hospital staff, we have come to realize that there are a few doctors who are genuinely committed and sensitive to this issue (such as those individuals who have emerged as the core group of key trainers). Many doctors reported that even when they have suspected cases of domestic violence in the past, they did not have the information or tools to refer women to needed services.

2. Our experience of training doctors as revealed in the evaluation is that doctors do recognise domestic violence as the cause of many reported health complaints; however, they refrain from probing into the issue for a number of reasons. A component on gender-based violence must be incorporated into the medical education system and all doctors and paramedical staff should participate in ongoing training.

3. The expected roles of doctors, nurses and social workers must be defined clearly. There should be neither an overlap nor ambiguity. Doctors and nurses are required only to identify, document and refer victims to counselling and social support services. Counselling should be provided by social workers and they should be adequately trained to respond to this issue from a feminist perspective.

4. Training activities form the cornerstone of the project. It is imperative that the training model is sustainable and institutionalised in the system. This would allow for the ongoing training inputs to other hospitals of the BMC, as well as to medical associations.

5. While public hospitals are not granted a separate budget for training activities, our documented experience shows that such separate funding is necessary. We are in the process of assessing the impact of the training programme in detail in order to make concrete recommendations for separate allocations.

6. It is possible to run such a centre with hospital resources, if training, research and technical support are provided. Hospitals have the staff and physical infrastructure to support such a project, but hospital social workers need to be trained as counsellors to provide the required social and psychological support to women facing domestic violence.

7. Hospitals must maintain high standards with regard to documentation, case papers and medico legal records. In order to assess the quality of documentation and develop strategies for improvement, NGO-supported research is needed.

8. There is also a need to create and examine ways of improving the hospital's management information system in order to fully integrate such centres within the public hospital system.

9. Our experiences have demonstrated that, with the hospital-based crisis intervention model, the potential to identify cases of abuse at an earlier stage of the cycle of violence is in process. Such identification can help to prevent the severity of negative health consequences, further abuse, and risk of death. Such efforts would also reduce the burden placed on the health care system.

10. The degree of efficiency at the level of service delivery must be enhanced, as staff tends to get bogged down with the day-to-day management of the Crisis Centre.

11. From the beginning of the project, there was a concern we had about domestic violence getting medicalised. At all stages we have therefore tried to ensure that this does not happen.

12. In the face of the current state of health care and lack of financial and human resources, preventive and rehabilitative care becomes important. Energies are focused on providing the most basic, urgent care. Collaboration with an outside agency becomes beneficial, as it can provide support where necessary and create a permanent space in the public health system to address violence.

Vital importance of public hospital space

Sarita's husband filed for divorce and compensation of Rs 22 lakh, alleging that she was mentally ill. Sarita is a Telugu-speaking girl. On the date of the hearing in the Family Court, the judge directed the family court counsellor to get Sarita's story. The counsellor asked a lawyer from South India to speak to the girl, but the lawyer could not speak Sarita's language and they could not find anyone else knowing Telugu in court that day. The court then appointed the lawyer as Sarita's lawyer. Her lawyer who sensed that the woman was petrified and needed support referred Sarita to *Dilaasa*.

Sarita came to *Dilaasa* from the court with her husband and his family. We were able to find a health worker at the hospital who speaks Telugu through whom we established communication with her. Sarita looked pale and could barely talk. It was only when the door of the counselling room was closed that she relaxed a little. It was apparent that she was scared. She told us that she had been beaten twice in the last two years. She refused to go back to her house and was visibly scared of her husband and his family. She had fever and fainted in course of our interaction with her. So we decided to get her admitted to the hospital, as she needed to be away from her husband until we could talk to her and decide what needed to be done.

We followed our regular process of trying to admit her to the hospital. Her husband was not too keen on it, but we explained to him that the doctor would take the decision on this. After some negotiations with the doctors on duty, Sarita was finally admitted as an in-patient. In the process her husband grew suspicious of the action and insisted that he would take her home. The following day when the lawyer came with all the papers, we learnt that the husband had claimed that Sarita was mentally retarded and mentally ill. He had taken her to several psychiatrists in the city, private and public. At the Thane Mental hospital, she was given anti-psychotic drugs without a definite diagnosis. No case history had been documented in the case papers.

Sarita was slowly recovering at the hospital. By the second day there was a visible change in her. She told us how she was beaten up, kept in a dark room, and not allowed to meet anyone. She spoke about her childhood- her father was a teacher and had taken pains to educate his children. She was not good at studies though. She had no friend or relative in Mumbai. We wrote to her father and asked him to come immediately. Meanwhile the counsellors continued to provide support to Sarita with the help of a translator and held consultation with the lawyers for determining future pathways. It was apparent in these two days that Sarita was not mentally ill. It was decided not to engage in any psychological testing. Sarita soon got a

smile on her face. Her brother in law came nearly five days after her admission. We learnt that her family had been informed earlier that she was not being treated properly and had intervened and spoken to the husband and his family. They were aware of the court case. Sarita's father had sent a letter saying that they were taking her back now. Sarita then went back with her brother in law and is now living with her natal family with dignity.

But for the temporary shelter provided by the public hospital, Sarita would have had nowhere to go. The hospital not only provided her a safe shelter but also helped in her healing. The hospital provided a space that was neutral and innocuous. Her abusive husband and his family could not raise much objection to her staying there. Such a space then created an opportunity for Sarita to be provided the much required psychological and legal support and gave her time to contact her family and for them to come to her aid.

For NGO–GO collaboration

- Support and involvement from higher-level staff is crucial. The Medical Superintendent is also the Programme Director of Dilaasa. Her position and commitment to the project gave her the authority to make various positive changes within the system in order to integrate this programme.

- In addition to providing a physical space within the hospital for *Dilaasa;* top administration of the BMC must be fully committed to the Centre and take a full-fledged interest in the project. The staff of Bhabha Hospital must undergo training and be thoroughly oriented to the *Dilaasa* project and the issue of domestic violence. They should have a sense of ownership over the project.

- There was a vast difference in the institutional cultures of the NGO and GO. For example, the BMC functions within a bureaucratic and hierarchical structure. NGOs on the other hand aspire to run democratically. Decision-making often becomes a contentious issue. While the working group, the elected body of CEHAT is the decision making body of CEHAT, it was difficult for senior BMC officials to accept this. The expectation was for the Coordinator of the organisation to be taking all decisions. That the team could sit together and take decisions on project matters was not quite appreciated. There was a lot of dialogue and until a basic level of trust between the two agencies could be arrived at there was some tension. The BMC had to be more flexible and relax certain structures, while the NGO representatives had to make efforts to assimilate into the hospital culture.

- In addition to differences in institutional culture, differences exist between the BMC and CEHAT with regard to the framework used for looking at a problem such as domestic violence. There were debates between social and curative medical models. Differences in perceptions must be respected and our common goal of serving the needs of women victims and survivors must be emphasised without compromises. Without these efforts on the part of both parties, a successful collaboration is not possible.

- The Centre must be viewed by all parties as a joint initiative between the BMC and CEHAT. Staff of the Centre must be seen as staff of *Dilaasa*. The rules, protocols, procedures of the centre need to be worked out with the focus of providing the best services to women. Dilaasa is a hospital department and not an NGO. This identity should be enhanced.

Future pathways

- We have identified community health workers (CHWs) as a crucial link between the community and the health system, as they are often members of the communities in which they work and may be more able to identify women facing abuse. At the primary level of care, CHWs can be trained as para-counsellors in order to provide basic emotional support to women in the community.

- At all three levels of the Indian health system—primary, secondary and tertiary—there is a dire need for rigorous staff training, as is the development of an organized referral system among the three. Specialised centres or hospitals should act as sources of referral for primary level institutions. The ideal location for hospital-based crisis centres is at the secondary level. At both the primary and tertiary levels, women facing domestic violence should be identified and referred for counselling.

- An issue which remains to be thoroughly explored is the violence that health professionals themselves may be subjected to. There is a need to explore this issue through research and develop effective mechanisms to address it. For example, nurses themselves may be victims of domestic violence. During the last two years, few women employed by the system have sought support from *Dilaasa*. The reasons given by them for not accessing the available services include fear about others in their workplace coming to know about their victimisation. They also tend to view this problem as a personal one, further inhibiting their ability to seek needed assistance. While we realise the obvious need to further emphasise confidentiality in these cases, the Centre should also explore other strategies and other potential spaces where health care professionals can seek and receive adequate care. Nurses in particular spend a great deal of time with patients and can also be trained to be para-counsellors, given their gender and the fact that women are more likely to open to them than to male doctors. Thus, the need to provide services for this group of health professionals takes on an even more significant meaning.

- Within the health care system, there must be a set of strategies to expand the Centre's work at city and state levels, as well as at the level of the central government. Efforts need to be made to incorporate more activities aimed at prevention.

- *Dilaasa* is not an end in itself in our work to eliminate violence against women. We must form stronger links with larger social and political movements to eliminate all forms of violence against women, as well as against other vulnerable segments of society.

This is where Dilaasa is today

Expansion to Communities Primary/ Health Care Syst.

Domestic Violence a Health Issue as part of Medical & Nursing Curricula

Dilaasa

Domestic Violence a Health Issue as part of Medical & Nursing Curricula

Domestic Violence a Health Issue as part of Medical & Nursing

DILAASA: CRISIS CENTRE FOR WOMEN
INTAKE FORM

(Please tick the relevant information**)**

Reg No:

Date:

Time interview started:

Time interview ended:

Referred by:

Date of MLC (whether done from Dilaasa):

Name:

Age (DOB)

Religion

Muslim Christian
Hindu Others
Buddhist

Marital Status: Single Married (first/second wife) Separated, Widowed, Deserted, Living in relationship, Divorced, Others

Number of years of marriage/Date of Marriage:

Present address (Mention Landmark)

Safe address (Mention Landmark)

Phone No. Res.: **C/o.:** **Work place:**

Can we get in touch with you? If yes, where and how?
By Phone By letter can't get touch in touch with you

Relationship to the Safe address /phone number
Specify the relation. (Natal Family, Marital Family, Employers, Neighbors/Friends Others)

Name:

Education: Illiterate Primary (Specify) Secondary Higher education Graduate
Post graduate Vocational courses others

Occupation: Not Employed Domestic worker Informal sector (Specify)
Formal sector Self-Employed Home maker others

Financial status
Woman's Income (Daily wages/ Weekly/Monthly) _____
Family Income (Daily wages/ Weekly/Monthly)_____
Do you have any assets in your name? Movable/Immovable

Do you have any important documents with you?

Marriage certificate	Marriage photo	Birth certificate of children
Ration card	List of streedhan	Receipts of Jewelry
Investments in your name	Voter card	Health reports
Academic certificates	Property papers	Bank account

Information about children

Name of child	**Sex**	**Age**	**Any other information**

Her Relationship to the abuser: Husband Marital family (Specify) Natal family (Specify) Children Others

Name of abuser:

Address and Telephone Number of work place:

Police station nearest to residence:

Police station nearest to incident:

Date: **NC No.:**

Medical treatment:

If referred from hospital record the following from the case paper

What was found on examination?

What is the treatment prescribed?

Pregnant status: **Yes** **Months** **No** **NA**

DILAASA: CRISIS CENTRE FOR WOMEN
Section II History of Violence

Details of present/recent incident of violence

History of Violence
Number of years you have experienced violence:

Types of violence faced
(Please tick from each type of violence) (a body map can be used to help the woman talk about where she was assaulted)

Physical	Emotional	Sexual	Financial
Beating, slapping by hand	Verbal abuse	Forced sex	Not allowing her to seek employment
Pinching	Persistent criticism	Painful sex	Denying her access to any money.
Pulling hair	Isolation	Withholding sexual pleasure	Denying right to her own income
Pushing, shoving	Threats to kill her	Sexual advances from other family members	Asking her for an explanations for every expenditure
Twisting the arm	Threats to remarry	Denying her the use of contraceptives	Denying her food and shelter
Banging the head on the wall and floor	Husband not communicating with her	Forcing her to have children	-Demanding money
Punching the face		Forced oral sex	Dowry demands
Punching the chest	Threats against her family	Forced anal sex	Any others
Punching the abdomen	Suspicion	Any others	
Kicking the chest	Restricting Mobility		
Kicking the stomach	Humiliating her in public		
Kicking her on the face	Extra marital affair		
Belting the woman	Any other		
Human bites on different body parts			
Use of blunt instruments			
Use of sharp instruments			
Strangulation			
Forcing her to consume poison			
Any others			

Narrate incidents of violence and her life story:
What do you do after the incident of violence? (Cry, sit in a corner, leave the house, go to your natal home, talk to the children go to sleep, nothing carry on with work, make a police complaint, suicidal ideation)

In what way is the violence affecting your physical and psychological health?

Are there others family members affected by violence?

Name	Age	Sex	Type of violence and its effect.

SAFETY ASSESSMENT

The following questions could be asked to assess her safety. These are situations where there is a possibility that the woman may face more violence. By asking these questions, the counselor would help the woman gauge her own safety. The more the number of yeses, the unsafe her going back would be. After asking these questions, the counselor would ask her if she feels safe to go back. The woman may say she feels unsafe but wants to go back or may say she feels safe. Here it is important to draw up a safety plan with the woman so that she can protect herself. **A safety plan would have to be drawn up even if the woman answers "No" to the above questions.**

1. Has the physical violence increased in frequency over the past year?
2. Has the severity of physical violence increased over the past year? (from kicks and blows there is use of instruments?)
3. Does he or his family threaten to kill you? If yes, then do you believe that they can kill you?
4. Does he and/or his family threaten you with second marriage? If yes, how serious do you think the threat is?
5. Have you thought of committing suicide? If yes, then have you attempted it, do you have any plan of committing suicide?
6. Is he violent towards your children and/or other family members? If yes, then has this increased in the past year?

SAFETY PLAN

Safety plan discussed with woman (Physical and Psychological):

Expectations from the center (*In the woman's words)* **–**

DILAASA: CRISIS CENTRE FOR WOMEN
Section III Intervention
(Discussion with the woman)

Reg of complaints (MLC, Police complaint)

Medical (Refer her to an OPD/IPD, Explain the health complaints that the woman is suffering)

Emotional Support (Reassure her that violence is not her fault, help her to understand the pattern of abuse, share with her that she is not alone, coping mechanism make specific suggestion like attend women's meeting, engage in paid work, skill building etc, stress on her strengths,. helping her to link it to a larger oppressive structure in which we live and how violence against woman happens most of the time.)

Social Support (Income generation, Skill building, Educational Support for children such as Balwadi, boarding schools)

Shelter:

Police (Information and explanation on the importance of filing an NC and other complaints)

Legal Counseling (her rights, procedure for injunction, stay order, maintenance, divorce)

Impressions: Woman's Perception about her situation (a more holistic picture about her life)

Counselor's analysis of the woman's situation –

Future plan discussed with woman:

Reg of complaints:

Medical:

Emotional Support:

Social Support:

Safety/ Shelter:

Police:

Legal Aid:

Date **Feedback from the team**

DILAASA: CRISIS CENTRE FOR WOMEN
Follow up session

Name: **File No.** **Reg. No.**

Discussion with the woman: ***Date:***

Safety Assessment and Plan:

Reg of complaints:

Medical:

Emotional Support:

Social Support:

Safety/ Shelter:

Police:

Legal Aid:

Future Plan:

Team Feedback: